42 CFR 440.60

G. OPTOMETRISTS

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The fee schedule is described in section D "Physicians".

42 CFR 440.120

H. **EYEGLASSES**

Payment for lenses and a standard frame is made on a fee-for-service basis. Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients.

42 CFR 440.130

Diagnostic, Preventive, Screening, and Rehabilitative Services

Diagnostic and rehabilitative substance abuse services are reimbursed by Medicaid on a fee-for-service basis when provided by or through a licensed substance abuse treatment program that is under contract with, or directly operated by, a Local County Comprehensive Substance Abuse Plan licensed in accordance with Section 62A-2-101-116, Utah Code Annotated, as amended.

Medicaid payments will be the lesser of (1) the billed usual and customary charges to the general public; or (2) the established fee schedule.

42 CFR 440.70

J. HOME HEALTH SERVICES

Home Health services are paid a uniform fee per visit unless either a lower amount is billed or a contract rate is competitively bid and accepted by the State. The uniform fee is established statewide and will be the same for all providers. The fee schedule may be increased to reflect changes in economic trends and conditions.

MEDICAL SUPPLIES AND EQUIPMENT
42 CFR 440.70 ©

GENERAL

For items of DME that have an HCPC code, (except for specialized wheelchairs), payment will be made to the supplier based on the lowest of:

(a) Billed usual and customary charges to the general public, or
(b) The established Medicaid fee schedule, or
The negotiated price, or
(C) The lowest qualified bidder who meets all quality of care and service delivery requirements.

SPECIALIZED WHEELCHAIRS

Electric wheelchairs and wheelchairs with special configurations, which do not fit into HCPC definitions, will be priced using the following criterion:

PRIOR APPROVAL OF ALL PRICING -- "Specialized wheelchairs" require prior approval by the Medicaid agency. Approval is required for all components used to customize the wheelchair costing more than $10 each. Components must be: 1) described in writing, 2) priced using manufacturers' list, and 3) approved by the Medicaid agency. Component parts costing less than $10 and the related labor costs are covered by the $200 design fee and by operating margins.

MANUFACTURERS PUBLISHED CATALOG PRICE LESS DISCOUNT -- "Specialized wheelchairs, including electric wheelchairs, are manually priced. Specialized wheelchairs that are not electric are priced at the manufacturer's published catalog price less 25%. Specialized wheelchairs that are electric are priced at the manufacturer's published catalog price less 20%. In addition a $200 design fee is added to configure, assemble and modify the wheelchair. Electric wheelchairs with specialized steering and positioning systems will be paid an additional design fee of $200 when prior approval is obtained.

1/19/96

DURABLE MEDICAL EQUIPMENT NOT COVERED BY HCPC DEFINITIONS

This policy is intended to address isolated problems ~~were~~ where HCPC definitions and related fees do not correlate with equipment approved by the Medicaid Agency. Providers should not look to this policy for routine pricing. The policy assures that suppliers are not paid less than the acquisition cost paid to the equipment manufacturer.

PRICING POLICY -- This policy is limited to durable medical equipment that is not covered by the HCPC codes, but is approved as medically necessary by the Medicaid Agency. The DME must be approved and payment will be the greater of:

a) Manufactures list price less 40%

b) Manufacturers invoice including shipping, but net of all discounts, plus an add-on of 10% with a ceiling of $100.

1/19/96

T.N. # 95-018 Supersedes T.N.# NEW

Approval Date 01/24/96 Effective Date 10/01/95

42 CFR 440.90

L. CLINIC SERVICES

Clinic services are paid differently depending on the type of services rendered. Such payments are limited to the amount paid by Medicare as specified in 42 CFR 447.321. Subject to these limitations, payments are determined as follows:

1. Dialysis Clinics - Payment for renal dialysis is based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges. Fees are based on the Medicare payment in Salt Lake County for dialysis.

2. Surgical Centers - Payment is based on a percentage of usual and customary billed charges. The percentage is established by the Pricing Unit in the Bureau of Policy and Planning and sent to the Bureau of Medicaid Management Information Systems for claims payment.

3. Alcohol and Drug Clinics - Payment is based on the established fee schedule unless a lower amount is billed. Fees will be set based on historical payments for specific HCPC codes.

4. Licensed Birthing Centers - Payment is based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges. Fees are based on discounted rates established for physicians.

5. Clinic Services for Physical Therapy and Occupational Therapy - Payments for physical/occupational therapy are based on the established fee schedule unless a lower amount is billed. Fees are established by discounting historical charges, by professional judgement, and by the physical therapy and occupational therapy fee schedule. Since the amount of physical therapy and occupational therapy is limited, the select case management committee of the clinic facility will determine which type (physical therapy or occupational therapy) will be provided for the patient by the clinic facility. The amount of physical therapy provided will affect the amount of occupational therapy available, and vice versa.

42 CFR 440.100

M. DENTAL SERVICES AND DENTURES

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The fees are established by discounting historical billed charges and by professional judgment to encourage efficient, effective, and economical dental services.

Urban Counties

As an incentive to improve client access to dental services in urban counties (Weber, Davis, Salt Lake, and Utah counties), dental providers (excluding UMAP/state-funded clinics) treating 100 or more clients per year will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less. Also, dentists willing to sign an agreement to see 100 or more clients during the next year will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less.

Rural Counties

As an incentive to improve client access to dental services in rural counties (all counties except Weber, Davis, Salt Lake, and Utah), dental providers in these counties (including UMAP/state-funded clinics) will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less.

42 CFR 440.110

N. PHYSICAL THERAPY

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed the usual and customary charges to private pay patients. Fees are established by discounting historical charges and by professional judgement.

OCCUPATIONAL THERAPY

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed the usual and customary charges to private pay patients. Fees are established by discounting historical charges, and by professional judgement.

42 CFR 440.120 O. PROSTHETIC DEVICES AND BRACES

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. Fees are established by discounting historical charges, by professional judgment and by discounting published price lists.